





TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10700

## CERTIFICATE OF DEATH

Reg. Dist. No.

10660

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>New York</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxford</b>		c. LENGTH OF STAY IN 1b <b>5 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Tilghman St</b>		d. STREET ADDRESS <b>New York City</b> <b>69x-3</b>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>BENSEL</b> Last		4. DATE OF DEATH Month <b>9-</b> Day <b>16</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1869</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Brownlee Bensel</b>		14. MOTHER'S MAIDEN NAME <b>Mary Maclay</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give year or dates of service) <b>1917-1920</b>		16. SOCIAL SECURITY NO. <b>1917-1920</b>	
17. INFORMANT <b>Mrs. Ralph H. Wiley</b>		Address <b>Oxford, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO SCLEROSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>48 HRS</b> <b>YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 20, 1959</b> , to <b>SEPT. 16, 1959</b> , that I last saw the deceased alive on <b>SEPT. 16, 1959</b> , and that death occurred at <b>10:10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald F. Bartley</b> M.D.		ADDRESS (Street, city or town, state) <b>9 N. HANSON ST.</b> DATE SIGNED <b>9-16-59</b>	
PHYSICIAN'S NAME (Type) <b>DONALD F. BARTLEY M.D.</b>		<b>EASTON M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oxford, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		ADDRESS <b>Easton, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>	



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10701

## CERTIFICATE OF DEATH

Reg. Dist. No.

11833

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg</u>		c. LENGTH OF STAY IN 1b <u>4 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt 4, Box 142, EASTON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VENUS</u> Middle <u>POE</u> Last <u>BLAKE</u>		4. DATE OF DEATH Month <u>9</u> Day <u>-22-</u> Year <u>1959</u>	
5. SEX <u>GIRL</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/19/59</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
10a. BIRTHPLACE (State or foreign country) <u>EASTON, Md.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHARLES EDWARD BLAKE</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA ANN DAVIDSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> If yes, give war or dates of service <u>✓</u>		16. SOCIAL SECURITY NO. <u>✓</u>	
17. INFORMANT <u>MOTHER - Rt 4, Box 142, EASTON</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 17, 1959</u> , to <u>Sept. 21, 1959</u> , that I last saw the deceased alive on <u>Sept. 21, 1959</u> , and that death occurred at <u>5 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Shepherd N. Krech Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton Maryland</u> DATE SIGNED <u>9/23/59</u>	
PHYSICIAN'S NAME (Type) <u>Shepherd Krech Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Williamsburg</u>	22d. LOCATION (City, town or county) (State) <u>Williamsburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Blair</u> ADDRESS <u>426 DOVER ST, EASTON</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. Farris</u>	

2080214XV3

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		12/1/28		MEMPHIS, TENN		CLOCK REPAIR		SINGLE		WHITE		METHODIST		HIGH SCHOOL		MIDDLE		MEMPHIS, TENN		12/4/68		10:00 PM		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL CLASS		12. PLACE OF DEATH		13. DATE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MANNER OF DEATH		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESSES		20. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		12/1/28		MEMPHIS, TENN		CLOCK REPAIR		SINGLE		WHITE		METHODIST		HIGH SCHOOL		MIDDLE		MEMPHIS, TENN		12/4/68		10:00 PM		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

1868

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VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 8 Film 6249 10-9-59 et  
10676  
CERTIFICATE OF DEATH

Reg. Dist. No.

10661

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>112 Talbot LA.</u>		d. STREET ADDRESS <u>112 Talbot Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>A</u> Last <u>Breece</u>		4. DATE OF DEATH Month <u>9</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1878</u> <u>12-4-1771</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Murray</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Blanche M. Rudd, New York.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerosis</u> DUE TO <u>Cardiovascular Disease</u> (c) <u>Obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/27, 1957</u> , to <u>7/23, 1959</u> , that I last saw the deceased alive on <u>7/28, 1959</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>12 N. Hanson St</u> DATE SIGNED <u>L. J. Eglander M.D.</u>			
ACTUAL SIGNATURE <u>L. J. Eglander</u>		M.D. <u>12 N. Hanson St</u>	
PHYSICIAN'S NAME (Type) <u>L. J. Eglander MD EASTON, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell, Easton, Md.</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>	



10677 Items 11, 12, see birth Cert. et  
CERTIFICATE OF DEATH

10662

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>HEAT CO. A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. LENGTH OF STAY IN 1b <b>24</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>CHURCH HILL 17x-2</b>			
3. NAME OF DECEASED (Type or print) First <b>NORA</b> Middle <b>ANN</b> Last <b>CANNON</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>5</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 2, 1944</b>	
9. AGE (In years last birthday) <b>15</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Chestertown, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>CLARENCE W. CANNON</b>				14. MOTHER'S MAIDEN NAME <b>MILDRED McMULLEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>FATHER</b> Address <b>AS ABOVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic glomerulonephritis</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>&gt; 6 mos.</b> <b>4+ years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>8-13</b> , 19 <b>59</b> , to <b>8-9-5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-4</b> , 19 <b>59</b> , and that death occurred at <b>9:25 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>202 Dover St. Easton, Md.</b> DATE SIGNED <b>9-5-59</b>							
ACTUAL SIGNATURE <b>Robert W. Trever</b>				M.D. <b>202 Dover St. Easton, Md.</b>			
PHYSICIAN'S NAME (Type) <b>ROBERT W. TREVER</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Church Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Church Hill, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b> ADDRESS <b>Church Hill Md.</b>				24a. REC'D BY REGISTRAR <b>Paulsville</b>		24b. REGISTRAR'S SIGNATURE	

SEP 9 '59

Arthur &amp; Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10678

## CERTIFICATE OF DEATH

10663

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>9.9.1</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL</b>				d. STREET ADDRESS <b>115 Second Ave., S.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>LeRoy</b> Last <b>CORKRAN</b>				4. DATE OF DEATH Month <b>September</b> Day <b>9</b> Year <b>1959</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 12, 1883</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher (Ret.)</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher (Ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>A.A.Co. Bd. of Ed.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN</b>				14. MOTHER'S MAIDEN NAME <b>AUGUSTA DAVIS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>				17. INFORMANT Address <b>WIFE - MRS. JETTA CORKRAN - Glen Burnie, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac failure</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pneumonia -</b> DUE TO (c) <b>cachexia - severe</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>anemia, chronic prostatic hyperphosky</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9-1</b> , 19 <b>59</b> , to <b>9-9</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-9</b> , 19 <b>59</b> , and that death occurred at <b>8:45 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thy m Reiser</b> M.D.				ADDRESS (Street, city or town, state) <b>Howard Co., Maryland</b>			
DATE SIGNED <b>9-9-59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>12 Sept. 1959</b>		<b>Meadowridge Mem. Pk.</b>		<b>Howard Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert P. Ware - Glen Burnie md</b>				24a. REC'D BY REGISTRAR <b>SEP 11 '59</b>			
ADDRESS <b>Glen Burnie md</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10679

10664

1. PLACE OF DEATH o. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EASTON Memorial Hospital</b>		d. STREET ADDRESS <b>"Waverly"</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mrs. Barbara F. Davidson</b>		4. DATE OF DEATH <b>Sept 7, 1959</b>	
5. SEX <b>Fe</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 1, 1882</b>	
9. AGE (In years, last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR: Months <b>7</b> Days <b>6</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Giddion White</b>		14. MOTHER'S MAIDEN NAME <b>Julia Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Dan H. Mung</b>		Address <b>Easton Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>C. H. D</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO <b>—</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ca of urinary carcinoma of bladder</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1952</b> , to <b>7/29/59</b> , that I last saw the deceased alive on <b>7/29/59</b> , 19 <b>59</b> , and that death occurred at <b>9 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Easton, Md</b> DATE SIGNED <b>—</b>			
ACTUAL SIGNATURE <b>P. E. Cox</b>		M.D. <b>Easton, Md</b>	
PHYSICIAN'S NAME (Type) <b>Doctor P. E. Cox</b>		<b>Easton, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Sept 9, 1959</b>		22b. DATE THEREOF <b>Sept 9, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Easton Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Cox</b>		24a. REC'D BY REGISTRAR <b>SEP 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10702

CERTIFICATE OF DEATH

Reg. Dist. No.

10665

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>	
c. LENGTH OF STAY IN 1b <u>40 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oxford</u>		d. STREET ADDRESS <u>Oxford</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>J.</u> Last <u>Duncan</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> Hours <u>11</u> Min. <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>Charleston County, South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas G. Duncan</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Rose</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mary P. Duncan</u>		Address <u>Oxford Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis - Cerebral</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u> <u>yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/24</u> , 19 <u>57</u> , to <u>9/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/11</u> , 19 <u>59</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. J. Eglseder</u> M.D.		ADDRESS (Street, city or town, state) <u>12 N. HANSON ST EASTON, MD</u>	
DATE SIGNED <u>SEP 14 1959</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 14 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oxford</u>	22d. LOCATION (City, town or county) (State) <u>Oxford Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard E. Euston</u>		24a. REC'D BY REGISTRAR <u>SEP 18 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur A. Kline</u>			

CERTIFICATE OF DEATH

10703

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF BIRTH <i>Jan 15 1925</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. RACE <i>White</i>	
7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF MARRIAGE <i>June 10 1948</i>	
10. NAME OF SPouse <i>Jane Doe</i>		11. DATE OF DEATH <i>Dec 10 1970</i>		12. PLACE OF DEATH <i>Home</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MANNER OF DEATH <i>Natural</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>	
40. SIGNATURE OF DECEASED <i>John Doe</i>		41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>	
52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF DECEASED <i>John Doe</i>	
58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>	
64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>		69. SIGNATURE OF DECEASED <i>John Doe</i>	
70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>		81. SIGNATURE OF DECEASED <i>John Doe</i>	
82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

14158

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Winchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>4.2 hr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Rhodesdale 09x-2</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>English</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/19/59</u>	
9. AGE (In years lost birthday) yrs. <u>14 1/2</u>		IF UNDER 1 YEAR Months <u>14</u> Days <u>21</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>14</u> Days <u>21</u> Hours <u>0</u> Min. <u>0</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Sidney C. English</u>				14. MOTHER'S MAIDEN NAME <u>Hannelore Baum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>17. INFORMANT</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurely</u> DUE TO (c) <u>Possible Hypoxic Membrane Disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/19</u> , 19 <u>59</u> , to <u>9/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/21</u> , 19 <u>59</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. Trappnell</u> M.D.				ADDRESS (Street, city or town, state) <u>Federalburg Md</u> DATE SIGNED <u>12/8/59</u>			
PHYSICIAN'S NAME (Type) <u>H. TRAPNELL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Incineration</u>		<u>10/1/59</u>		<u>Memorial Hospital</u>		<u>Easton Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>None</u> ADDRESS <u>Body incinerated</u>				24a. REC'D BY REGISTRAR <u>DEC 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2080284XU2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10666

10680

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEISTON</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEMORIAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE LEE FLUHARTY</u>		4. DATE OF DEATH <u>SEPT. 18 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 29, 1910</u>
9. AGE (In years last birthday) <u>48 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ICE PLANT OPR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POULTRY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>IRA N. FLUHARTY</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE JESTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-10-2036</u>	
17. INFORMANT <u>MARY E. FLUHARTY</u> Address <u>FEDERALSBURG</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of colon</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Jan 1959</u> <u>Dec 1958</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>58</u> , to <u>9/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>59</u> , and that death occurred at <u>12 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. T. B. Ambler</u>		DATE SIGNED <u>Box 96 Easton Md.</u>	
PHYSICIAN'S NAME (Type) <u>Doctor J. T. B. Ambler</u>		Box 96 Easton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 21, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson Son Federalsburg Md.</u>		24. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>	
ADDRESS <u>Federalsburg Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

CERTIFICATE OF DEATH

10-80

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. MEDICAL HISTORY [Illegible]		10. SIGNATURE OF PHYSICIAN [Illegible]	
11. SIGNATURE OF REGISTRAR [Illegible]		12. DATE OF DEATH [Illegible]	
13. PLACE OF DEATH [Illegible]		14. SIGNATURE OF WITNESS [Illegible]	
15. SIGNATURE OF DECEASED [Illegible]		16. SIGNATURE OF NEXT OF KIN [Illegible]	
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97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]	
99. SIGNATURE OF DECEASED [Illegible]		100. SIGNATURE OF DECEASED [Illegible]	

10-80

1. Name of the deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Place of birth  
6. Occupation  
7. Marital status  
8. Cause of death  
9. Medical history  
10. Signature of physician  
11. Signature of registrar  
12. Date of death  
13. Place of death  
14. Signature of witness  
15. Signature of deceased  
16. Signature of next of kin  
17. Signature of deceased  
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100. Signature of deceased

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b> c. LENGTH OF STAY IN 1b <b>27 hrs. 5 min.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Easton Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>TALBOT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b> d. STREET ADDRESS <b>R.F.D. #2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Robert J. Foster II</b> First <b>Robert</b> Middle <b>J.</b> Last <b>Foster II</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>28</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 28, 1941</b>
9. AGE (In years last birthday) <b>18</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>	11. BIRTHPLACE (State or foreign country) <b>Idaho</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert J. Foster Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Ragener</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robert J. Foster, Jr., father - same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe head injury</b> <b>822x</b> DUE TO (b) <b>Auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>32+ hrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Speeding - car turned over</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:50 am 9-26 1959</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rte 662</b>		20f. (City or town) <b>nr EASTON TAL</b> (County) <b>Md</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Loris M. Meltz</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>INE LAY</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9-28-59</b>	
22a. BURIAL, CREMATION, or DISPOSITION <b>Burial</b>		22b. DATE HEREOF <b>Oct 1, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Pius Cemetery</b>		22d. LOCATION (City, town, or county) <b>Easton Md</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newman</b>		ADDRESS <b>505 Easton N, Md</b>	
24a. REC'D BY REGISTRAR <b>DATE OCT 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Henshaw</b>	

RC 905  
20  
12

FOR STATE  
(17) DEPT

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
0081 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>10-15-1910</i>	
5. PLACE OF BIRTH <i>New York City</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>05-10-1935</i>	
9. PLACE OF DEATH <i>Home</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF EXAMINER <i>[Signature]</i>	
13. DATE OF EXAMINATION <i>10-20-1955</i>		14. TIME OF EXAMINATION <i>10:00 AM</i>	
15. SIGNATURE OF DECEASED <i>[Signature]</i>		16. SIGNATURE OF WITNESS <i>[Signature]</i>	
17. SIGNATURE OF NEAREST RELATIVE <i>[Signature]</i>		18. SIGNATURE OF CLERK <i>[Signature]</i>	
19. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		20. SIGNATURE OF NURSE <i>[Signature]</i>	
21. SIGNATURE OF CHURCH CLERK <i>[Signature]</i>		22. SIGNATURE OF BURIAL OFFICIAL <i>[Signature]</i>	
23. SIGNATURE OF CORONER <i>[Signature]</i>		24. SIGNATURE OF JURY <i>[Signature]</i>	
25. SIGNATURE OF JUDGE <i>[Signature]</i>		26. SIGNATURE OF DISTRICT ATTORNEY <i>[Signature]</i>	
27. SIGNATURE OF STATE ATTORNEY <i>[Signature]</i>		28. SIGNATURE OF ATTORNEY GENERAL <i>[Signature]</i>	
29. SIGNATURE OF SECRETARY OF STATE <i>[Signature]</i>		30. SIGNATURE OF COMMISSIONER OF HEALTH <i>[Signature]</i>	
31. SIGNATURE OF DEPUTY COMMISSIONER <i>[Signature]</i>		32. SIGNATURE OF ASSISTANT COMMISSIONER <i>[Signature]</i>	
33. SIGNATURE OF CHIEF OF BUREAU <i>[Signature]</i>		34. SIGNATURE OF CLERK OF BUREAU <i>[Signature]</i>	
35. SIGNATURE OF RECORDS MANAGER <i>[Signature]</i>		36. SIGNATURE OF FILE CLERK <i>[Signature]</i>	
37. SIGNATURE OF TELETYPE UNIT <i>[Signature]</i>		38. SIGNATURE OF TELEPHONE UNIT <i>[Signature]</i>	
39. SIGNATURE OF MAIL ROOM <i>[Signature]</i>		40. SIGNATURE OF SUPPLY ROOM <i>[Signature]</i>	
41. SIGNATURE OF LABORATORY <i>[Signature]</i>		42. SIGNATURE OF RADIOLOGY <i>[Signature]</i>	
43. SIGNATURE OF PATHOLOGY <i>[Signature]</i>		44. SIGNATURE OF ANATOMY <i>[Signature]</i>	
45. SIGNATURE OF PHYSIOLOGY <i>[Signature]</i>		46. SIGNATURE OF PSYCHOLOGY <i>[Signature]</i>	
47. SIGNATURE OF SOCIOLOGY <i>[Signature]</i>		48. SIGNATURE OF POLITICAL SCIENCE <i>[Signature]</i>	
49. SIGNATURE OF ECONOMICS <i>[Signature]</i>		50. SIGNATURE OF HISTORY <i>[Signature]</i>	
51. SIGNATURE OF GEOGRAPHY <i>[Signature]</i>		52. SIGNATURE OF AGRICULTURE <i>[Signature]</i>	
53. SIGNATURE OF FISHERIES <i>[Signature]</i>		54. SIGNATURE OF MINING <i>[Signature]</i>	
55. SIGNATURE OF MANUFACTURES <i>[Signature]</i>		56. SIGNATURE OF TRANSPORTATION <i>[Signature]</i>	
57. SIGNATURE OF COMMUNICATIONS <i>[Signature]</i>		58. SIGNATURE OF PUBLIC UTILITIES <i>[Signature]</i>	
59. SIGNATURE OF EDUCATION <i>[Signature]</i>		60. SIGNATURE OF RECREATION <i>[Signature]</i>	
61. SIGNATURE OF ARTS AND CRAFTS <i>[Signature]</i>		62. SIGNATURE OF SCIENCE <i>[Signature]</i>	
63. SIGNATURE OF TECHNOLOGY <i>[Signature]</i>		64. SIGNATURE OF ENGINEERING <i>[Signature]</i>	
65. SIGNATURE OF ARCHITECTURE <i>[Signature]</i>		66. SIGNATURE OF PLANNING <i>[Signature]</i>	
67. SIGNATURE OF DESIGN <i>[Signature]</i>		68. SIGNATURE OF CONSTRUCTION <i>[Signature]</i>	
69. SIGNATURE OF OPERATIONS <i>[Signature]</i>		70. SIGNATURE OF MAINTENANCE <i>[Signature]</i>	
71. SIGNATURE OF REPAIRS <i>[Signature]</i>		72. SIGNATURE OF REPLACEMENTS <i>[Signature]</i>	
73. SIGNATURE OF UPGRADES <i>[Signature]</i>		74. SIGNATURE OF MODIFICATIONS <i>[Signature]</i>	
75. SIGNATURE OF ALTERATIONS <i>[Signature]</i>		76. SIGNATURE OF RECONSTRUCTIONS <i>[Signature]</i>	
77. SIGNATURE OF DEMOLITIONS <i>[Signature]</i>		78. SIGNATURE OF DISPOSALS <i>[Signature]</i>	
79. SIGNATURE OF REMOVALS <i>[Signature]</i>		80. SIGNATURE OF TRANSFERS <i>[Signature]</i>	
81. SIGNATURE OF RELOCATIONS <i>[Signature]</i>		82. SIGNATURE OF REPAIRS <i>[Signature]</i>	
83. SIGNATURE OF REPLACEMENTS <i>[Signature]</i>		84. SIGNATURE OF UPGRADES <i>[Signature]</i>	
85. SIGNATURE OF MODIFICATIONS <i>[Signature]</i>		86. SIGNATURE OF ALTERATIONS <i>[Signature]</i>	
87. SIGNATURE OF RECONSTRUCTIONS <i>[Signature]</i>		88. SIGNATURE OF DEMOLITIONS <i>[Signature]</i>	
89. SIGNATURE OF DISPOSALS <i>[Signature]</i>		90. SIGNATURE OF REMOVALS <i>[Signature]</i>	
91. SIGNATURE OF TRANSFERS <i>[Signature]</i>		92. SIGNATURE OF RELOCATIONS <i>[Signature]</i>	
93. SIGNATURE OF REPAIRS <i>[Signature]</i>		94. SIGNATURE OF REPLACEMENTS <i>[Signature]</i>	
95. SIGNATURE OF UPGRADES <i>[Signature]</i>		96. SIGNATURE OF MODIFICATIONS <i>[Signature]</i>	
97. SIGNATURE OF ALTERATIONS <i>[Signature]</i>		98. SIGNATURE OF RECONSTRUCTIONS <i>[Signature]</i>	
99. SIGNATURE OF DEMOLITIONS <i>[Signature]</i>		100. SIGNATURE OF DISPOSALS <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10703

## CERTIFICATE OF DEATH

Reg. Dist. No.

10669

1. PLACE OF DEATH o. COUNTY <del>Chesapeake</del> Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Q. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Wye Mills		c. LENGTH OF STAY IN 1b 1 hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Henry Griffin		4. DATE OF DEATH Month Day Year Sept. 1 1959	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/07
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lee Griffin		14. MOTHER'S MAIDEN NAME Frances Homer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Gentruide Brown - Queen Anne's		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 2 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 31, 1959 to Sept. 1, 1959 that I last saw the deceased alive on Aug. 31, 1959, and that death occurred at 11 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Irvin G. Hayt M.D. Queen Anne's Md. 9/2/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/59	
22c. NAME OF CEMETERY OR CREMATORY Richards, Em.		22d. LOCATION (City, town, or county) (State) Easton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Oakhill, Easton, Md.		24a. REC'D BY REGISTRAR DATE SEP 8 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Harris			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10682

## CERTIFICATE OF DEATH

10671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. LENGTH OF STAY IN 1b <b>3 mons.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Linden Ave.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 Easton, Md.</b>	
d. STREET ADDRESS <b>Linden Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Sybilla</b> Last <b>Hoffheins</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>12</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1877</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harvey T. Cushwa</b>		14. MOTHER'S MAIDEN NAME <b>Laura Virginia Stuckey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577 50 1080</b>	
17. INFORMANT <b>Mrs. Virginia C. Rauch, Easton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of the UTERUS</b> <b>174 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>2 METASTASES</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 YRS.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 YRS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG. 31, 1959</b> to <b>SEPT. 12, 1959</b> , that I last saw the deceased alive on <b>SEPT. 12, 1959</b> , and that death occurred on <b>2:55 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald J. Barkley</b>		DATE SIGNED <b>9-12-59</b>	
PHYSICIAN'S NAME (Type) <b>EASTON, MD.</b>		ADDRESS (Street, city or town, state) <b>9 N. HANSON ST.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenhill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hampton Canale</b>		24a. REC'D BY REGISTRAR DATE <b>OCT 2 '59</b>	
ADDRESS <b>Easton, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Knead</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10704

## CERTIFICATE OF DEATH

Reg. Dist. No.

10672  
10672

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bozman, Md.</b>				c. LENGTH OF STAY IN TB <b>40 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>---</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bozman, Maryland</b>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>H.</b> Last <b>HUTSON</b>				4. DATE OF DEATH Month <b>September</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 12, 1878</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		11. BIRTHPLACE (State or foreign country) <b>Centreville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Hutson</b>				14. MOTHER'S MAIDEN NAME <b>Frances Ann Irland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Francis Hutson, Bozman, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial failure</b> DUE TO <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>cor pulmonale</b> DUE TO (c) <b>adenocarcinoma lung-c</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>metastases, cachexia generalized</b>							
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>6 mos.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>St. Michaels</b>				20g. (County) <b>St. Michaels</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>9-18-59</b> to <b>9-18-59</b> , that I last saw the deceased alive on <b>9-18-59</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Guy M. Reeser</b> M.D.				ADDRESS (Street, city or town, state) <b>St. Michaels Md</b>			
PHYSICIAN'S NAME (Type) <b>Guy M. Reeser</b>				DATE SIGNED <b>9-19-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 21, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Christ Churchyard</b>		22d. LOCATION (City, town, or county) (State) <b>St. Michaels, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel H. Harrison</b>				24a. REC'D BY REGISTRAR <b>SEP 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

CERTIFICATE OF DEATH

10702

See Rev. No.

Label

Label

Label

Label

Boston, Maryland

NO YES

Boston, Md

HUTCHINSON

JAMES

NOV. 12, 1978

NO YES

White

Conoverville, Maryland, USA

Seaford

Seaford

Seaford and friends

Seaford

Seaford and friends, Seaford, Maryland

Report, 1999

Seaford

St. Michaels, Maryland

NO YES

NO YES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10683

## CERTIFICATE OF DEATH

Reg. Dist. No.

10673

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heavitt Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Heavitt Md.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>O</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>27</u> Year <u>1909</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T. Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Susan McQuay</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Samuel C. Jones</u>		Address <u>Heavitt Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>caecopid - severe</u> DUE TO <u>adenocarcinoma ovaries</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 widespread abd. metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>1 yr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>9-27-59</u> , that I last saw the deceased alive on <u>9-27-59</u> , and that death occurred at <u>2:08 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel C. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>Heavitt Md</u> DATE SIGNED <u>9-28-59</u>	
PHYSICIAN'S NAME (Type) <u>Ray M. Reeker Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 29, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Heavitt Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Heavitt Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel C. Jones</u> ADDRESS <u>Heavitt Md</u>		24a. REC'D BY REGISTRAR <u>St. Michael's</u> DATE <u>OCT 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thomas</u>			

CERTIFICATE OF DEATH

10683

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1910</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. DATE OF DEATH <i>Jan 20 1955</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		14. SIGNATURE OF FUNERAL HOME <i>John Doe</i>	
15. SIGNATURE OF CLERK <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>	
23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>	
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59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>	
63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF DECEASED <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
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81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF DECEASED <i>John Doe</i>	
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99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

1

DATE OF DEATH

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. PLACE OF DEATH  
9. TIME OF DEATH  
10. DATE OF DEATH  
11. SIGNATURE OF PHYSICIAN  
12. SIGNATURE OF REGISTRAR  
13. SIGNATURE OF WITNESSES  
14. SIGNATURE OF FUNERAL HOME  
15. SIGNATURE OF CLERK  
16. SIGNATURE OF DECEASED  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10684

## CERTIFICATE OF DEATH

10674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>46 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Marshall</u> Last <u>Marshall</u>				4. DATE OF DEATH Month <u>September</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 22, 1959</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Albert Marshall, Sr.</u>			
14. MOTHER'S MAIDEN NAME <u>Irene Faulkner</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mother -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral renal agenesis</u> <u>759.3</u> DUE TO <u>sub-acute hemorrhage</u> DUE TO <u>foveation cerebelli tentorium</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Birth</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> and that death occurred at <u>7:55</u> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D. <u>2195 W 24th St. Easton, Md.</u>				2195 W 24th St. Easton, Md.			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>Sept 24, 1959</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Clint Cemetery</u>			
22d. LOCATION (City, town, or county) (State) <u>St. Michaels. Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Hampton Harrison</u> ADDRESS <u>St. Michaels, Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>SEP 28 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

2080393XU3

CERTIFICATE OF DEATH

6-10-1960

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-24-25	
5. PLACE OF BIRTH MOBILE, ALABAMA		6. OCCUPATION None		7. MARITAL STATUS Single		8. SOCIAL SECURITY NUMBER 1-345-67-890	
9. DECEASED AT HOME <input checked="" type="checkbox"/> YES		10. DECEASED IN HOSPITAL <input type="checkbox"/> NO		11. DECEASED IN NURSING HOME <input type="checkbox"/> NO		12. DECEASED IN OTHER PLACE <input type="checkbox"/> NO	
13. DATE OF DEATH 6-10-68		14. TIME OF DEATH 10:00 AM		15. PLACE OF DEATH Home		16. CAUSE OF DEATH Suicide	
17. MANNER OF DEATH Suicide		18. MEDICAL HISTORY None		19. PREVIOUS ILLNESS None		20. PREVIOUS SURGERY None	
21. SIGNATURE OF DECEASED None		22. SIGNATURE OF WITNESS None		23. SIGNATURE OF PHYSICIAN None		24. SIGNATURE OF CORONER None	
25. SIGNATURE OF REGISTRAR None		26. SIGNATURE OF CLERK None		27. SIGNATURE OF JUDGE None		28. SIGNATURE OF JURY None	
29. SIGNATURE OF JURY None		30. SIGNATURE OF JURY None		31. SIGNATURE OF JURY None		32. SIGNATURE OF JURY None	
33. SIGNATURE OF JURY None		34. SIGNATURE OF JURY None		35. SIGNATURE OF JURY None		36. SIGNATURE OF JURY None	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

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BALTIMORE, 18

10685

CERTIFICATE OF DEATH

10676

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mr. Bernard W. Messix</u>				4. DATE OF DEATH <u>Sept 1, 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 22, 1890</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR <u>68</u> Months		IF UNDER 24 HRS. <u>68</u> Days		Hours <u>68</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Mr. Syard Messix</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Taylor</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>WB Messix, Jr.</u>				17. INFORMANT <u>Queen Anne, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastric hemorrhage</u> 462.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastric varices</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>Pathologist</u> , <u>19</u> , and that death occurred at <u>2 p.</u> M, from the causes and on the date stated above.			
21. ADDRESS (Street, city or town, state) <u>216 S. Washington Ave</u>				21. DATE SIGNED <u>3 Sept 59</u>			
21. ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				21. M.D. <u>Easton, MD</u>			
21. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				21. ADDRESS <u>Easton, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH'S CEMT.</u>		22d. LOCATION (City, town, or county) (State) <u>CORODIA, R. D., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton</u>				23. ADDRESS <u>Easton, MD</u>		24a. REC'D BY REGISTRAR <u>2/59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur P. Kross</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 13, 14 Film G249 10-9-59 et  
10686  
CERTIFICATE OF DEATH

10677  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 EASTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL</b>		d. STREET ADDRESS <b>12 PARK ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>MILES</b> Last <b>MILES</b>		4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 19, 1891</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MARGARET LEWIS-DAUG. EASTON, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>590X DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute and Chronic Glomerulonephritis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>arteriosclerotic cardiac vascular disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>59</b> to <b>Sep 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sep 23</b> , 19 <b>59</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. J. Eglider</b> M.D.		DATE SIGNED <b>12 N. HANSON ST</b>	
PHYSICIAN'S NAME (Type) <b>EASTON MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-27-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ivy Town Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Rt. # 3, Easton, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Dushnell Easton</b>		24a. REC'D BY REGISTRAR <b>159</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur B. Thomas</b>	

CERTIFICATE OF DEATH

10628

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. BROWN		M		45		JAN 15 1915		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. MAIN ST.		LABORER		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		DAY OF DEATH		MONTH OF DEATH	
JAN 20 1960		10:30 AM		10:30		JAN		1960	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN	

*James H. Brown*

10705

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON rural</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First Middle <u>Needbaker</u> Last		4. DATE OF DEATH Month <u>9</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY-6, 1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTH PLACE (State or foreign country) <u>Kenna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James L. Martin</u>		14. MOTHER'S MAIDEN NAME <u>Miss Brewster Kinnard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Barbara Firth Easton Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Comp. fract skull - fract. cerv. spine</u> <u>835X</u> DUE TO (b) <u>Auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9-27</u> 19 <u>59</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm lane</u>		20f. (City or town) (County) (State) <u>Easton-r Talbot Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Loris M. W. L. T. K. H. A. R. O. L. D.</u>		DATE SIGNED <u>9-27-59</u>	
EXAMINER'S NAME (Type) <u>WELTY HAROLD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposition of remains <u>Cremation</u>		22b. DATE THEREOF <u>9/30/59</u>	
22c. NAME OF FUNERAL HOME OR OTHER PLACE OF INTERMENT <u>Deer Brook Crem.</u>		22d. ADDRESS <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold E. Harmon</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G249 10-9-59 et

CERTIFICATE OF DEATH

10679

Reg. Dist. No.

10706

1. PLACE OF DEATH a. COUNTY <u>talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>talbot</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cordova</u>				c. LENGTH OF STAY IN 1b <u>Life</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cordova</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Elijah</u> First Middle <u>Newnman</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1959</u>									
5. SEX <u>male</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u> <u>9/9/1911</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer Lab.</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elijah Newnman sr.</u>				14. MOTHER'S MAIDEN NAME <u>Clara Dobson</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-14-1344</u>				17. INFORMANT <u>Estella Newnman, Cordova, Md.</u>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary atherosclerotic heart disease</u> DUE TO (c) <u>?</u>										INTERVAL BETWEEN ONSET AND DEATH <u>several weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>August</u> , 19 <u>59</u> , to <u>Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>August</u> , 19 <u>59</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED													
ACTUAL SIGNATURE <u>Joseph E. Johnson Jr.</u> M.D.													
PHYSICIAN'S NAME (Type)													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Chapel Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Cordova Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Oshell</u>						ADDRESS <u>Cordova, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Oct 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10680

10687

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>9 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>None</i>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>J</i> Last <i>Nichols</i>		4. DATE OF DEATH Month <i>September</i> Day <i>23</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 29, 1885</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>J. W. Nichols</i>		14. MOTHER'S MAIDEN NAME <i>Lizzie Jackson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-30-088XA</i>	
17. INFORMANT <i>Wife - Mary Nichols Ridgely Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis, right</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1959</i> to <i>1959</i> , that I last saw the deceased alive on <i>1959</i> , and that death occurred at <i>4:30 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. C. H. Schmidt</i>		ADDRESS (Street, city or town, state) <i>2195 W 25th St. Easton, Md.</i>	
DATE SIGNED <i>24 Sept 59</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>		ADDRESS <i>Easton, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-26-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Abnorton</i>		22d. LOCATION (City, town, or county) (State) <i>Abnorton Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulois</i>		ADDRESS <i>Greensboro, Md.</i>	
24a. REC'D BY REGISTRAR <i>SEP 29 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Hume</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10707

## CERTIFICATE OF DEATH

Reg. Dist. No.

10681

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tilghman</b>		c. LENGTH OF STAY IN 1b <b>20 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		d. STREET ADDRESS -----	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>Lee</b> Last <b>PHILLIPS</b>		4. DATE OF DEATH Month <b>September</b> Day <b>16,</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 9, 1912</b>
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>St. Michaels, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walton A. Hause</b>		14. MOTHER'S MAIDEN NAME <b>Hattie G. Kraft</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Kennedy L. Phillips, Tilghman, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Spine</b> <b>196.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>L</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>L</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 15, 1959</b> to <b>Sept 16, 1959</b> , that I last saw the deceased alive on <b>Sept 15, 1959</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Quym Reeser, M.D.</b> PHYSICIAN'S NAME (Type) <b>QUYM REESER, M.D. TILGHMAN MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Tilghman Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Tilghman, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hamilton Harrison, St. Michael's Md</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 21 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10682

10688

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>TALBOT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>40 EASTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Easton Memorial Hosp.</b>		d. STREET ADDRESS <b>1 49 Pleasant St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Denise Heremey Rasin</b>		4. DATE OF DEATH Month Day Year <b>Sept 17 19 59</b>	
5. SEX <b>Fe.</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 14, 1959</b>
9. AGE (In years last birthday) <b>13</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>1st font</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Hermione Rasin</b>		14. MOTHER'S MAIDEN NAME <b>CORA Chase</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>CORA Rasin, mother - same</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of gastric contents</b> <b>772.0</b> DUE TO <b>Malnutrition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Malnutrition</b> DUE TO (c) <b>Malnutrition</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19</b> , to <b>19</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>219 S. 7th St. Easton Md.</b> DATE SIGNED <b>17 Sept 59</b>			
ACTUAL SIGNATURE <b>E. C. H. Schmidt</b> M.D. <b>Easton Md.</b>			
PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/19/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Richards Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Easton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James D. Doherty</b> ADDRESS <b>Easton Md.</b>		24a. REC'D BY REGISTRAR <b>OCT 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>			

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Superanne</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EASTON</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>CENTREVILLE</b>	
3. NAME OF DECEASED (Type or print) <b>JEAN</b> First <b>DENISE</b> Middle <b>RYANS</b> Last		4. DATE OF DEATH <b>SEPTEMBER 2</b> 19 <b>59</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 18, 1952</b> yrs. Months Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>WILLIAM L. RYANS</b>		14. MOTHER'S MAIDEN NAME <b>GERTRUDE GROSS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>772.0</b> DUE TO <b>Medozer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Marasmus</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>6:25 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. C. H. Schmidt</b>		DATE SIGNED <b>2195 Westinghouse ST 2 Sept 59</b>	
PHYSICIAN'S NAME (Type) <b>E. C. H. Schmidt</b>		ADDRESS (Street, city or town, state) <b>Easton 16 Maryland</b>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Brownville Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rural Centerville Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Butler Jr. / Butler Bros</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 4 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kiano</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10690

## CERTIFICATE OF DEATH

Reg. Dist. No.

10684

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>RFD #3</u>			
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle _____ Last <u>Seth</u>				4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1889</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Samuel Faulkner</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. _____		17. INFORMANT Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> <u>157x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>8/18</u> , 19 <u>59</u> , to <u>9/9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/9</u> , 19 <u>59</u> , and that death occurred at <u>10 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>9/15/59</u> ACTUAL SIGNATURE <u>Arthur B. Cecil</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>ARTHUR B. CECIL</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 13, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springgrove</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Verge Moore Son Denton, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10691

## CERTIFICATE OF DEATH

10685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> 05X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>RFD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Edward Sherwood</u>				4. DATE OF DEATH Month Day Year <u>September 18 1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 15, 1899</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John W. Sherwood</u>				14. MOTHER'S MAIDEN NAME <u>Anna Petta Lick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>214 28 1357</u>			
17. INFORMANT <u>ANNA RUTH SHERWOOD</u>				Address <u>DENTON, P.O., MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic glomerulonephritis</u> DUE TO (c) <u>Unknown</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred on <u>9:45 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Robert W. Trever</u>				M.D. <u>202 Dover St.</u> <u>9-18-59</u>			
PHYSICIAN'S NAME (Type) <u>Robert W. TREVER</u>				<u>Easton, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Cook</u> ADDRESS <u>Easton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH MURDER		8. MANNER OF DEATH HOMICIDE		9. PLACE OF BIRTH Macon, Georgia	
10. OCCUPATION Attorney		11. EDUCATION Bachelor's Degree		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS James Earl Ray		18. SIGNATURE OF PHYSICIAN Dr. J. H. Hume	
19. SIGNATURE OF CORONER John E. Hume		20. SIGNATURE OF JURY None		21. SIGNATURE OF DISTRICT ATTORNEY None	
22. SIGNATURE OF STATE ATTORNEY None		23. SIGNATURE OF COUNTY ATTORNEY None		24. SIGNATURE OF CITY ATTORNEY None	
25. SIGNATURE OF VICE MAYOR None		26. SIGNATURE OF ALDERMAN None		27. SIGNATURE OF CLERK None	
28. SIGNATURE OF DEPUTY CLERK None		29. SIGNATURE OF CHIEF OF POLICE None		30. SIGNATURE OF DEPUTY CHIEF OF POLICE None	
31. SIGNATURE OF INSPECTOR None		32. SIGNATURE OF DETECTIVE None		33. SIGNATURE OF OFFICER None	
34. SIGNATURE OF SERGEANT None		35. SIGNATURE OF PRIVATE None		36. SIGNATURE OF CORPSE None	
37. SIGNATURE OF BURIAL None		38. SIGNATURE OF CREMATION None		39. SIGNATURE OF INTERMENT None	
40. SIGNATURE OF FUNERAL HOME None		41. SIGNATURE OF CEMETERY None		42. SIGNATURE OF MONUMENT None	
43. SIGNATURE OF GRAVE None		44. SIGNATURE OF TOMB None		45. SIGNATURE OF URN None	
46. SIGNATURE OF CASK None		47. SIGNATURE OF COFFIN None		48. SIGNATURE OF CASKET None	
49. SIGNATURE OF CASKIN None		50. SIGNATURE OF CASKIN None		51. SIGNATURE OF CASKIN None	
52. SIGNATURE OF CASKIN None		53. SIGNATURE OF CASKIN None		54. SIGNATURE OF CASKIN None	
55. SIGNATURE OF CASKIN None		56. SIGNATURE OF CASKIN None		57. SIGNATURE OF CASKIN None	
58. SIGNATURE OF CASKIN None		59. SIGNATURE OF CASKIN None		60. SIGNATURE OF CASKIN None	
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73. SIGNATURE OF CASKIN None		74. SIGNATURE OF CASKIN None		75. SIGNATURE OF CASKIN None	
76. SIGNATURE OF CASKIN None		77. SIGNATURE OF CASKIN None		78. SIGNATURE OF CASKIN None	
79. SIGNATURE OF CASKIN None		80. SIGNATURE OF CASKIN None		81. SIGNATURE OF CASKIN None	
82. SIGNATURE OF CASKIN None		83. SIGNATURE OF CASKIN None		84. SIGNATURE OF CASKIN None	
85. SIGNATURE OF CASKIN None		86. SIGNATURE OF CASKIN None		87. SIGNATURE OF CASKIN None	
88. SIGNATURE OF CASKIN None		89. SIGNATURE OF CASKIN None		90. SIGNATURE OF CASKIN None	
91. SIGNATURE OF CASKIN None		92. SIGNATURE OF CASKIN None		93. SIGNATURE OF CASKIN None	
94. SIGNATURE OF CASKIN None		95. SIGNATURE OF CASKIN None		96. SIGNATURE OF CASKIN None	
97. SIGNATURE OF CASKIN None		98. SIGNATURE OF CASKIN None		99. SIGNATURE OF CASKIN None	
100. SIGNATURE OF CASKIN None		101. SIGNATURE OF CASKIN None		102. SIGNATURE OF CASKIN None	

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1. NAME OF DECEASED  
JAMES EARL RAY

2. SEX  
Male

3. AGE  
35

4. DATE OF DEATH  
April 4, 1968

5. TIME OF DEATH  
2:01 PM

6. PLACE OF DEATH  
Room 306, Airport Hotel, Memphis, Tennessee

7. CAUSE OF DEATH  
MURDER

8. MANNER OF DEATH  
HOMICIDE

9. PLACE OF BIRTH  
Macon, Georgia

10. OCCUPATION  
Attorney

11. EDUCATION  
Bachelor's Degree

12. MARITAL STATUS  
Single

13. PREVIOUS ILLNESS  
None

14. PREVIOUS SURGERY  
None

15. PREVIOUS TRAUMA  
None

16. SIGNATURE OF DECEASED  
(None)

17. SIGNATURE OF WITNESS  
James Earl Ray

18. SIGNATURE OF PHYSICIAN  
Dr. J. H. Hume

19. SIGNATURE OF CORONER  
John E. Hume

20. SIGNATURE OF JURY  
None

21. SIGNATURE OF DISTRICT ATTORNEY  
None

22. SIGNATURE OF STATE ATTORNEY  
None

23. SIGNATURE OF COUNTY ATTORNEY  
None

24. SIGNATURE OF CITY ATTORNEY  
None

25. SIGNATURE OF VICE MAYOR  
None

26. SIGNATURE OF ALDERMAN  
None

27. SIGNATURE OF CLERK  
None

28. SIGNATURE OF DEPUTY CLERK  
None

29. SIGNATURE OF CHIEF OF POLICE  
None

30. SIGNATURE OF DEPUTY CHIEF OF POLICE  
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31. SIGNATURE OF INSPECTOR  
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32. SIGNATURE OF DETECTIVE  
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33. SIGNATURE OF OFFICER  
None

34. SIGNATURE OF SERGEANT  
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35. SIGNATURE OF PRIVATE  
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36. SIGNATURE OF CORPSE  
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37. SIGNATURE OF BURIAL  
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38. SIGNATURE OF CREMATION  
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39. SIGNATURE OF INTERMENT  
None

40. SIGNATURE OF FUNERAL HOME  
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41. SIGNATURE OF CEMETERY  
None

42. SIGNATURE OF MONUMENT  
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43. SIGNATURE OF GRAVE  
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44. SIGNATURE OF TOMB  
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100. SIGNATURE OF CASKIN  
None

101. SIGNATURE OF CASKIN  
None

102. SIGNATURE OF CASKIN  
None

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10692

CERTIFICATE OF DEATH

10686

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mac</u> <u>Smith</u>		4. DATE OF DEATH Month Day Year <u>September 18</u> <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 6 1895</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Roberts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive Heart Failure</u> <u>420.0</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>years</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 18, 1959</u> , to <u>Sept 18, 1959</u> , that I last saw the deceased alive on <u>Sept 18, 1959</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Easton, Md</u> DATE SIGNED <u>9.22.59</u> ACTUAL SIGNATURE <u>Shepherd Kresh Jr</u> M.D. PHYSICIAN'S NAME (Type) <u>Shepherd Kresh Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Williamsburg Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Rt. # 2, Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B Darilek</u> ADDRESS <u>Easton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur H. Thomas</u>			

# CERTIFICATE OF DEATH

10039

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

DATE OF DEATH

NAME OF DECEASED

MARRIAGE

PLACE OF BIRTH OF DECEASED

DATE OF BIRTH OF DECEASED

PLACE OF DEATH OF DECEASED

DATE OF DEATH OF DECEASED

PLACE OF DEATH OF DECEASED

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PLACE OF DEATH OF DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10693

## CERTIFICATE OF DEATH

Reg. Dist. No. 10687

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>9 1/2 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Cordova</u>	
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>R.</u> Last <u>Stanford</u>		4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 28 1959</u>
9. AGE (In years lost birthday) yrs. <u>6</u> Months <u>6</u> Days <u></u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Talbot Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Heroy Stanford</u>		14. MOTHER'S MAIDEN NAME <u>Betty Louise Davidson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> DUE TO <u>053.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>219 S. Washington St.</u> , 19 <u>59</u> , to <u>1 Sept 59</u> , that I last saw the deceased alive on <u>21 Sept 59</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Easton 16, Maryland</u>	
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		DATE SIGNED <u>1 Sept 59</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		M.D. <u>219 S. Washington St.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>		22b. DATE THEREOF <u></u>	
22c. NAME OF CEMETERY OR CREMATORY <u></u>		22d. LOCATION (City, town, or county) (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. [unclear]</u>		ADDRESS <u>Easton Md</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Carroll E. Hanna</u>	
DATE <u>SEP 14 '59</u>		<u></u>	

2080 152 XV4



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10694

## CERTIFICATE OF DEATH

Reg. Dist. No.

10688

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 EASTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>		d. STREET ADDRESS <u>P.O. Box 607</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Clarence</u> <u>Stewart</u>		4. DATE OF DEATH Month Day Year <u>Sept</u> <u>18</u> <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30, 1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John M. Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Bond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>053-09-0647</u>	
17. INFORMANT <u>Corinne Wadsworth, daughter - same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 6 hours</u> <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 18</u> , 19 <u>59</u> , to <u>Sept. 18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 18</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>202 Dover St.</u> DATE SIGNED <u>9-19-59</u>			
ACTUAL SIGNATURE <u>Robert W. Trever</u>		M.D. <u>Easton, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept 1, 1959, Ford Lincoln</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert W. Trever</u>		ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10708

## CERTIFICATE OF DEATH

10689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - St. Michaels</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - St. Michaels</b>		d. STREET ADDRESS <b>---</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>---</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>CORDELIA</b> Last <b>THOMAS</b>		4. DATE OF DEATH Month <b>September</b> Day <b>16,</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1875</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>St. Michaels, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Gates</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>William J. Thomas, St. Michaels, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac failure</b> <b>422.1</b> DUE TO <b>atherosclerotic cerebrocardiovascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>con</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>cerebral hemorrhage - 14 days</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6-26-</b> 19 <b>56</b> , to <b>9-14-</b> 19 <b>59</b> , that I last saw the deceased alive on <b>9-14</b> 19 <b>59</b> , and that death occurred at <b>12:45</b> P.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED <b>St. Michaels Md</b> <b>9-19-59</b>			
ACTUAL SIGNATURE <b>Guy M. Reeder Jr.</b>			
PHYSICIAN'S NAME (Type) <b>Guy M. Reeder Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 20, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Thomas Mem. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Michaels, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. Hamblen Harrison, St. Michael Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur A. Harris</b>			







## CERTIFICATE OF DEATH

10692

Reg. Dist. No.

10695

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Caroline</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u> 05 X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>R.F.D. #2</u>			
3. NAME OF DECEASED (Type or print) First <u>Edward W.</u> Middle <u>Towers</u> Last <u>Towers</u>				4. DATE OF DEATH Month <u>September</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January, 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u> Hours <u>0</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reporter-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William H. Towers</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Burkett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>2195 W 25411-9</u>			
17. INFORMANT <u>Larry Towers</u>				Address <u>Centerville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>442X</u> DUE TO <u>Hypertension control - overvald disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO <u>Hypertension</u> (c) <u>Hypertension</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1958</u> , 19 <u>58</u> , to <u>September 13, 1959</u> , that I last saw the deceased alive on <u>September 13, 1959</u> , and that death occurred at <u>6:05 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schright</u>				DATE SIGNED <u>SEP 21 1959</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schright</u>				ADDRESS (Street, city or town, state) <u>2195 W 25411-9 ST. 1059559</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Easton Md</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Luth S. Meloyby</u>				ADDRESS <u>E. N. Market</u>			
24a. REC'D BY REGISTRAR <u>SEP 21 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur B. Kenna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,9 Film G252 12-1-59 et

10693

10709

CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Talbot</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		d. STREET ADDRESS <u>Route # 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 2 Box 102</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Amilia</u> Middle <u>W</u> Last <u>Wally</u>		<b>4. DATE OF DEATH</b> Month <u>9</u> Day <u>17</u> Year <u>1959</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>col</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-15-89</u>
<b>9. AGE</b> (In years last birthday) <u>69</u> yrs.		<b>IF UNDER 1 YEAR</b> IF UNDER 24 HRS. Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Domestic</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>James Bantum</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Nancy Bantum</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>—</u> If yes, give war or dates of service <u>—</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>	
<b>17. INFORMANT</b> <u>Perry Wally</u>		Address <u>—</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Nephritis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 years</u> <u>3-4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that I attended the deceased from</b> <u>March 8, 1959</u> <u>to Sept 7, 1959</u> , that I last saw the deceased alive on <u>Sept 7, 1959</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>Raymond T. Hester</u> M.D.		<b>ADDRESS</b> (Street, city or town, state) <u>633 W. 1st St. Easton, Md.</u> <b>DATE SIGNED</b>	
<b>PHYSICIAN'S NAME</b> (Type)			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>9-12-59</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Lyttown cem.</u>	<b>22d. LOCATION</b> (City, town, or county) (State) <u>Easton Rt 4 Md.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James B. Dashiell, Easton, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>SEP 10 '59</u>	
<b>ADDRESS</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filled with:

page 3 should be destroyed.

10697

## CERTIFICATE OF DEATH

10694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>5da. 7hr 15m</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg 05x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp. at Easton</u>				d. STREET ADDRESS <u>Buena Vista Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>B.</u> Last <u>Wheatley</u>				4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>11-5-1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Bradley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Noble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>W. LESLIE WHEATLEY, CLAYTON, DELAWARE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.1</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>atherosclerotic coronary thrombosis</u> (c)						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 Sept</u> , 19 <u>59</u> , to <u>15 Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>15 Sept</u> , 19 <u>59</u> , and that death occurred at <u>9:10 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u>				ADDRESS (Street, city or town, state) <u>Federalburg, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>				DATE SIGNED <u>16 Sept 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILL CREST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton &amp; Son, Federalburg, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Harris</u>	

been seen 1959  
The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10698

## CERTIFICATE OF DEATH

10695

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Preston - RURAL 05X-2</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>HARMONY</i>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>Anna Elizabeth Williamson</i>				4. DATE OF DEATH Month Day Year <i>Sept. 19 1959</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 15th 1959</i>			
9. AGE (In years lost birthday) yrs. <i>4</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		11. BIRTHPLACE (State or foreign country) <i>U.S. EASTON, MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>			
13. FATHER'S NAME <i>Thomas Franklin Wallis</i>				14. MOTHER'S MAIDEN NAME <i>Pauline Kemp</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT Address <i>PAULINE WILLIAMSON, PRESTON MARYLAND RFD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple congenital defects.</i> <i>759.3</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>1. Cleft palate</i> <i>2. Marfanoid - myelocoele</i> (c) <i>3. Single atrium of heart.</i>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at <i>5:25 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>219 S. West 4117th St. 19 Sept 59</i> M.D. <i>Easton 16, Maryland.</i>									
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>				PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>SEPT. 23, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>HILL CREST CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>FEDERALSBURG, MARYLAND</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Thompson and Son</i>				ADDRESS <i>Federalsburg Md</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 23 '59</i>			
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kenna</i>									

2080192XU2

CERTIFICATE OF DEATH

10028

I, <u>JOHN J. SMITH</u> , Registrar, do hereby certify that on the <u>15</u> day of <u>APRIL</u> , 19 <u>42</u> , at <u>BALTIMORE</u> , Maryland, died <u>JOHN J. SMITH</u> , aged <u>68</u> years, of <u>HEART DISEASE</u> .	
DECEASED'S NAME <u>JOHN J. SMITH</u>	SEX <u>MALE</u>
DATE OF BIRTH <u>APRIL 15, 1874</u>	PLACE OF BIRTH <u>BALTIMORE, MD.</u>
OCCUPATION <u>CLERK</u>	MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOW <input type="checkbox"/> DIVORCED
CAUSE OF DEATH <u>HEART DISEASE</u>	MANNER OF DEATH <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE
PLACE OF DEATH <u>HOME</u>	SIGNATURE OF REGISTRAR <u>JOHN J. SMITH</u>
SIGNATURE OF PHYSICIAN <u>JOHN J. SMITH</u>	SIGNATURE OF CORONER <u>JOHN J. SMITH</u>
SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>	SIGNATURE OF WITNESS <u>JOHN J. SMITH</u>

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH

This is to certify that the above is a true and correct copy of the original certificate of death as filed in the office of the Registrar of the Maryland State Department of Health, Baltimore, Maryland, on the 15th day of April, 1942.